ORIGINAL

An Agenda for Public Health

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Presented to the American Public Health Association
Boston, Massachusetts
November 14, 1988

(GREETINGS TO HOSTS, GUESTS, FRIENDS, ETC.)

I'M TRULY GRATEFUL FOR THE RECOGNITION YOU'VE GIVEN ME TODAY. THIS IS, AFTER ALL, THE ASSOCIATION WHOSE MEMBERS FORM THE BASE OF OUR AMERICAN SYSTEM OF MAINTAINING AND IMPROVING THE HEALTH STATUS OF ALL OUR CITIZENS.

AS SURGEON GENERAL, I'VE ALWAYS BEEN AWARE OF THE PRIMARY FUNCTION OF MY OFFICE, WHICH IS THAT OF PUBLIC PERSUASION ... IN OTHER WORDS, CONVINCING PEOPLE THAT THEY SHOULD DO THE THINGS THEY OUGHT TO DO -- OR OUGHT NOT TO DO -- FOR THEIR OWN GOOD.

BUT, EARLY ON, I REALIZED THAT YOU, THE MEMBERS OF THE A.P.H.A., WERE ON THE FRONT LINE OF PUBLIC HEALTH. I COULD TALK ABOUT A PARTICULAR HEALTH ISSUE ... I COULD GET OTHERS TO TALK ABOUT IT ... AND I COULD PLANT IT IN THE CONSCIOUSNESS OF THE NATION.

BUT IF YOU WERE INVOLVED IN SOME PUBLIC HEALTH ACTIVITY, THEN IT WOULD GET DONE AND PEOPLE WOULD BENEFIT.

I THINK WE'VE BOTH COME A LONG WAY IN UNDERSTANDING EACH OTHER OVER THE COURSE OF THE PAST 7 YEARS. AND JUST IN THE NICK OF TIME, TOO, IF I MAY SAY SO, BECAUSE, BY THIS TIME NEXT YEAR, I WILL BE A CIVILIAN AGAIN, BACK IN MUFTI, AND THIS EXTRAORDINARY EXPERIENCE WILL BE BEHIND ME.

SO THIS IS MY LAST A.P.H.A. MEETING AS YOUR SURGEON GENERAL.

AND I INTEND TO TAKE FULL ADVANTAGE OF THAT FACT. I WANT TO TALK WITH YOU ABOUT SOME OF THE THINGS THAT ARE -- OR OUGHT TO BE -- ON THE PUBLIC HEALTH AGENDA.

AND THAT WOULD INCLUDE SOME THINGS THAT EACH OF YOU MIGHT THINK ABOUT, WHATEVER YOUR PROFESSIONAL POSITION, AND A FEW THINGS THAT THE A.P.H.A. ITSELF MIGHT THINK ABOUT.

BILL McBEATH SAID I COULD ONLY HAVE A HALF-HOUR. THAT SORT OF CRAMPS THINGS A BIT, BUT I'VE MADE SOME DRASTIC CUTS IN MY LIST SO THAT WE CAN GET OUT IN TIME TO SEE THE 11 O'CLOCK NEWS.

LET ME BEGIN WITH SOMETHING FAMILIAR: HEALTH PROMOTION AND DISEASE PREVENTION.

I SUPPOSE BRINGING THIS UP IS LIKE CARRYING COALS TO NEWCASTLE, IF ANYONE REMEMBERS WHAT THAT MEANS. AFTER ALL, THE A.P.H.A. DID HELP THEN-SURGEON GENERAL RICHMOND AND THE U.S. PUBLIC HEALTH SERVICE PRODUCE THE LAND-MARK "SURGEON GENERAL'S REPORT" TITLED HEALTHY PEOPLE.

THAT WAS IN 1979.

SINCE THEN WE'VE PUBLISHED THE 1990 OBJECTIVES AND WE ARE NOW IN THE PROCESS OF FORMULATING THE OBJECTIVES FOR THE YEAR 2000. I'M DELIGHTED WITH THE WAY THE NATION HAS TAKEN UP MANY OF THESE OBJECTIVES AND I HOPE THE PROCESS CONTINUES.

BUT THERE ARE TWO ASPECTS OF THE PROCESS THAT NEED ATTENTION. THE FIRST RELATES TO DATA.

IF YOU'VE BEEN FOLLOWING THE PROCESS AT ALL, YOU KNOW THAT SOME OBJECTIVES CANNOT BE MET BECAUSE WE STILL HAVE NO BASELINE DATA TO GIVE US A HANDLE ON THOSE PARTICULAR HEALTH ISSUES.

IN SOME INSTANCES, THE PROBLEM IS ONE FOR OUR SCIENTISTS. THEY HAVE TO COME UP WITH A NEW METHODOLOGY FOR SECURING THE MISSING DATA.

THIS HAS BEEN THE CASE WITH MEASURING AVERAGE DAILY SODIUM INGESTION, FOR EXAMPLE, OR FOR DETERMINING THE PREVALENCE OF FETAL ALCOHOL SYNDROME. AND OUR PHYSICAL SCIENTISTS AND EPIDEMIOLOGISTS ARE COMING UP WITH GOOD, NEW STUDIES IN THESE AND OTHER AREAS. BUT PROGRESS IS SLOW AND THAT HAS TO BE A CONCERN.

ANOTHER AREA WHERE THE LACK OF DATA IS ESPECIALLY ACUTE IS THE AREA OF PUBLIC AWARENESS. WITHOUT A GOOD SENSE OF WHAT THE PUBLIC KNOWS AND DOESN'T KNOW, WE CANNOT INTELLIGENTLY EVALUATE OUR PUBLIC EDUCATION EFFORTS.

THEY ARE COSTLY. YET, THEY MAY -- OR MAY NOT -- BE EFFECTIVE. WE SIMPLY DON'T KNOW.

IN ANY CASE, THERE IS A GAP BETWEEN OUR GOALS, AS WE EXPRESS THEM IN RHETORIC, AND OUR GOALS, AS WE EXPRESS THEM IN HARD DATA. RIGHT NOW, I'M AFRAID WE MAY BE RELYING TOO MUCH ON RHETORIC. AND THAT'S JUST NOT GOOD ENOUGH.

OUR LACK OF A STRONG DATA ACROSS THE BOARD IS NOT A NEW PROBLEM AND I CERTAINLY DON'T PRETEND THAT I DISCOVERED IT. BUT I RAISE IT NOW, BECAUSE I BELIEVE IT WILL BE SOLVED WHEN ALL THE DISCIPLINES WITH A STAKE IN PUBLIC HEALTH AGREE TO FOCUS ON THE ISSUE -- TOGETHER -- AND BRING THEIR COMBINED INTEREST AND STRENGTH TO THE DEVELOPMENT OF BETTER INFORMATION RELATIVE TO HEALTH PROMOTION AND DISEASE PREVENTION.

WE'RE STILL ESSENTIALLY USING THE DISEASE MONITORING MODEL, WHICH HAS BEEN SO SUCCESSFUL FOR US THROUGHOUT THE PAST CENTURY'S WAR ON INFECTIOUS DISEASE.

IT IS ALSO THE MODEL WITH WHICH MOST OF US RECEIVED OUR PROFESSIONAL TRAINING. IT'S FAMILIAR AND IT STILL SEEMS TO WORK FOR MUCH OF THE NON-PREVENTION ACTIVITY IN PUBLIC HEALTH.

HOWEVER, I DON'T BELIEVE IT'S AN ADEQUATE MODEL FOR THE DEVELOPMENT OF DATA APPROPRIATE TO PREVENTION AND HEALTH PROMOTION.

WE NEED INNOVATION IN THIS AREA OF DATA DEVELOPMENT, AND I WOULD ASSUME THAT THE MEMBERS OF THIS ORGANIZATION WOULD BE THE PRIMARY INNOVATORS.

I AM REMINDED OF THE WORK DONE ABOUT 10 YEARS AGO BY MRS. DOROTHY RICE, WHEN SHE WAS THE DIRECTOR OF THE NATIONAL CENTER FOR HEALTH STATISTICS. YOU MAY RECALL HER EFFORTS TO MEASURE THE "BURDEN OF ILLNESS." IT WAS A VERY IMPORTANT STEP FORWARD IN THE WHOLE AREA OF MORBIDITY MEASUREMENT.

BUT WE HAVEN'T TRAVELED MUCH FARTHER ALONG THE PATH FIRST SKETCHED OUT BY MRS. RICE AND HER N.C.H.S. COLLEAGUE, DR. JACK FELDMAN.

MY CONCERN IS THAT THIS KIND OF "CULTURE LAG" IN DATA DEVELOPMENT AND COLLECTION STILL PERSISTS AND IT IS SERIOUSLY RESTRICTING OUR OVERALL EFFORT TO STRENGTHEN HEALTH PROMOTION AND DISEASE PREVENTION ACTIVITIES THROUGHOUT PUBLIC HEALTH.

BUT LET ME LEAVE THIS PARTICULAR "AGENDA ITEM" WITH A FINAL COMMENT.

I BELIEVE THE EMPHASIS THAT BEGAN IN 1979 -- THE NEW AND STRONG EMPHASIS ON PREVENTION AND ON HEALTH PROMOTION -- WAS ABSOLUTELY RIGHT. AND, DESPITE SOME HANDICAPS IN DATA AND IN OUR LEVEL OF SCIENTIFIC KNOWLEDGE IN THESE AREAS, WE'VE MADE TREMENDOUS PROGRESS ON BOTH FRONTS.

I CONGRATULATE THE PUBLIC HEALTH PROFESSION FOR ACHIEVING SO MUCH IN JUST A DECADE OF EFFORT.

NOW, LET ME MOVE ON TO AGENDA ITEM NUMBER TWO.

AS YOU KNOW, ONE OF THE FEW THINGS A SURGEON GENERAL ACTUALLY OPERATES IS THE LITTLE P.H.S. OFFICE OF INTERNATIONAL HEALTH. FORTUNATELY FOR THE COUNTRY AND FOR THE WORLD, EACH AGENCY OF THE U.S. PUBLIC HEALTH SERVICE HAS ITS OWN INTERNATIONAL PROGRAM AND SO WE'RE ABLE TO MAKE SOME PROGRESS IN BILATERAL AND MULTILATERAL ARRANGEMENTS AROUND THE WORLD.

I THINK SOME OF THE THINGS THAT C.D.C. HAS ACCOMPLISHED ... SOME OF THE RESEARCH FUNDED BY N.I.H. ... THE COOPERATIVE WORK OF THE F.D.A. ... AND SO ON ... THOSE P.H.S. EFFORTS HAVE BEEN VERY IMPORTANT NOT ONLY FOR THE INDIVIDUALS AND THE NATIONS INVOLVED, BUT FOR THE CAUSE OF PEACE AS WELL.

I REALLY BELIEVE THAT. AND I'VE TALKED WITH MANY, MANY OF THE TOP HEALTH LEADERS OF THE WORLD, DURING MY VISITS TO GENEVA FOR THE ANNUAL WORLD HEALTH ASSEMBLY AND IN THE COURSE OF MANY OTHER TRIPS TO EUROPE, ASIA, AND THE MIDDLE EAST. AND THEY ALL SAY THE SAME THING: "P.H.S., WE LOVE YOU."

NEVERTHELESS, OUR INTERNATIONAL HEALTH EFFORT IS ALMOST AN AFTERTHOUGHT, AS FAR AS OVERALL PUBLIC HEALTH POLICY IS CONCERNED. AND AT SOME OF THE HIGHER LEVELS OF OUR DEPARTMENT, IT HAS BEEN SEEN AS LITTLE MORE THAN AN EXCUSE TO GET OUT OF THE OFFICE AND OUT OF THE COUNTRY FOR A WEEK OR TWO.

AND I'M TOLD THIS HAS BEEN TRUE FOR MANY, MANY ADMINISTRATIONS.

I THINK THIS OFF-HAND, LOW-PRIORITY APPROACH TO INTERNATIONAL HEALTH IS A GRAVE WEAKNESS OF AMERICAN PUBLIC HEALTH POLICY.

THE ONE AREA WHERE WE'VE DONE EXTREMELY WELL IS IN REFERENCE TO AIDS. WE'VE SHARED OUR RESEARCH WITH OTHERS AND WE'VE RECEIVED MUCH COOPERATION AND COLLABORATION IN RETURN.

IT'S VERY REMINISCENT OF THE CAMPAIGN TO ERADICATE SMALLPOX, AND I CERTAINLY HOPE AND PRAY THAT WE'RE AS SUCCESSFUL IN THE GLOBAL FIGHT AGAINST AIDS AS WE WERE IN THE FIGHT AGAINST SMALLPOX.

BUT WE CAN'T HOP FROM ONE MAJOR INFECTIOUS DISEASE TO ANOTHER AND SAY THAT WE HAVE A "POLICY" FOR THE LONG TERM THAT IS APPROPRIATE TO THE NEEDS OF OUR GOVERNMENT, OF OUR CITIZENS, AND OF OUR FELLOW VOYAGERS ON THIS PLANET. IT JUST ISN'T.

AND IF WE REALLY BELIEVE THAT PREVENTION AND HEALTH PROMOTION ARE THE "WAVE OF THE FUTURE," WHY DON'T WE DO MORE TO EXPORT THOSE CONCEPTS TO OUR PUBLIC HEALTH COLLEAGUES AROUND THE WORLD?

AND IF IT'S EXCITEMENT YOU'RE LOOKING FOR, I CAN TELL YOU THAT GOING OVERSEAS WITH A STRONG ANTI-TOBACCO AND ANTI-ALCOHOL MESSAGE WILL PROVIDE YOU WITH MANY THRILLING ENCOUNTERS.

BUT MY POINT IS THAT OUR COUNTRY HAS A GREAT DEAL TO OFFER OTHER COUNTRIES IN RESPECT TO PUBLIC HEALTH -- AND WE HAVE A GREAT DEAL TO LEARN FROM THEM AS WELL.

BUT WE'LL NEVER HAVE THAT AS A COHERENT ELEMENT OF OUR OWN NATIONAL PUBLIC HEALTH POLICY, UNLESS PUBLIC HEALTH PROFESSIONALS, SUCH AS YOU, GET BEHIND THE IDEA AND DEMAND THAT IT HAPPEN.

I MUST TELL YOU -- MORE IN SORROW THAN IN ANGER -- THAT I'VE BEEN LOBBIED QUITE HARD BY MANY DIFFERENT AND CONTENDING HEALTH INTERESTS OVER THE PAST 7 YEARS. BUT RARELY HAVE I BEEN LOBBIED BY PUBLIC HEALTH PEOPLE ON AN INTERNATIONAL MATTER.

THAT DOESN'T MEAN I WOULD NECESSARILY HAVE CHANGED MY MIND ON THIS OR THAT INTERNATIONAL HEALTH ISSUE. YOU KNOW ME BETTER THAN THAT.

BUT THE NEXT SURGEON GENERAL MAY BE MORE RECEPTIVE. IN ANY CASE, I STRONGLY URGE ALL PUBLIC HEALTH PROFESSIONALS TO GIVE MORE ATTENTION TO ISSUES OF INTERNATIONAL HEALTH AND TO MAKE YOUR VIEWS KNOWN TO YOUR GOVERNMENT.

THIS IS A CASE WHERE THE SURGEON GENERAL CAN HAVE A LOT OF GOOD IDEAS, BUT PRESSURE FROM THE OUTSIDE IS WHAT WILL MAKE A DIFFERENCE. AND I HOPE YOU WILL THINK ABOUT THIS AND THAT YOU'LL SUPPORT A STRONGER, MORE VISIBLE APPROACH TO INTERNATIONAL HEALTH BY OUR GOVERNMENT.

A THIRD AGENDA ITEM RELATES TO SEVERAL ISSUES I'VE DEALT WITH OVER THE PAST 7 YEARS. IT HAS TO DO WITH MONEY AND IT HAS TO WITH THE GENERAL SHIFT IN THE DEMOGRAPHY OF OUR COUNTRY.

LET'S BEGIN BY LOOKING AT THAT POPULATION GROUP THAT WE CALL "CHILDREN." IT INCLUDES NOT ONLY NEONATES BUT ALSO ADOLESCENTS THROUGH TO AGE 18.

FOR 200 HUNDRED YEARS THIS AGE GROUP HAS DOMINATED AMERICAN LIFE AND THINKING AND CERTAINLY AMERICAN HEALTH AND WELFARE PLANNING.

BUT THAT'S CHANGING. FIVE YEARS AGO, FOR EXAMPLE, 28 PERCENT OF THE AMERICAN POPULATION WERE CHILDREN UNDER THE AGE OF 18, WHILE A SMALLER PROPORTION -- 21 PERCENT -- WERE ADULTS OVER THE AGE OF 55.

BUT, BY THE YEAR 2000 -- ONLY 11 YEARS FROM NOW -- THESE TWO POPULATION GROUPS WILL BE VIRTUALLY IN BALANCE. AND THEN, BY THE YEAR 2010, THE BALANCE WILL GO THE OTHER WAY:

* 24 PERCENT OF ALL AMERICANS WILL BE UNDER THE AGE OF 18, BUT...
* A HIGHER PROPORTION -- 26 PERCENT -- WILL BE OVER THE AGE OF 55.

OUR AMERICAN DEMOGRAPHICS ARE IN TRANSITION. AND FOLLOWING RIGHT BEHIND IS THE PARALLEL TRANSITION IN HEALTH PLANNING AND RESOURCE ALLOCATION.

THROUGHOUT THE YEARS, THE PUBLIC HEALTH PROFESSION HAS CAMPAIGNED HARD FOR ESSENTIAL MATERNAL AND CHILD HEALTH PROGRAMS. AND THE DEMOGRAPHIC STATISTICS HAVE ALWAYS SUPPORTED OUR CASE: CHILDREN AND YOUTH COMPRISED THE DOMINANT POPULATION GROUP.

BUT OUR STRATEGY FOR TOMORROW HAS TO BE DIFFERENT. WE'LL HAVE TO WORK HARD TO MAINTAIN -- MAYBE NOT EVEN BE ABLE TO INCREASE -- PUBLIC SUPPORT FOR CHILD HEALTH PROGRAMS IN THE 1990s AND BEYOND.

BUT WE MUST NOT FIGHT FOR THIS SUPPORT AT THE EXPENSE OF OTHER POPULATION GROUPS -- ESPECIALLY THE ELDERLY. RATHER, WE MUST SPEAK OUT SO THAT CHILDREN ARE PROVIDED WITH AT LEAST -- AND NOT LESS THAN -- THEIR PROPORTIONATELY FAIR SHARE OF OUR COUNTRY'S HEALTH RESOURCES.

BUT THERE'S ANOTHER TWIST TO THIS DEMOGRAPHIC REALITY.

THE LARGEST SINGLE GROUP OF POOR PEOPLE IN THE UNITED STATES IS MADE UP OF CHILDREN ... 12 MILLION OF THEM ... OR ABOUT 1 OF EVERY 4 AMERICANS UNDER THE AGE OF 18.

THIS IS SOMEWHAT MISLEADING, SINCE ALL CHILDREN LACK TANGIBLE ECONOMIC ASSETS OF THEIR OWN AND, THEREFORE, THEY ARE ALL "POOR." HENCE, WHAT WE REALLY MEAN IS THAT THE SINGLE LARGEST POPULATION OF POOR PEOPLE IN THE UNITED STATES IS MADE UP OF CHILDREN OF POOR FAMILIES.

TAKEN TOGETHER, I THINK THESE ARE TWO VERY POWERFUL -- AND POTENTIALLY NEGATIVE -- INFLUENCES ON THE FUTURE OF CHILD HEALTH SUPPORT IN THIS COUNTRY:

FIRST, THE FACT THAT CHILDREN WILL NO LONGER DOMINATE OUR DEMOGRAPHICALLY BASED HEALTH PLANNING, AND...

SECOND, THE FACT THAT A SIGNIFICANT NUMBER OF ALL CHILDREN WILL BE AT THE LOW END OF THE SOCIO-ECONOMIC SCALE.

I THINK THIS ADDS UP TO A MAJOR CHALLENGE FOR PUBLIC HEALTH LEADERSHIP IN OUR SOCIETY. IN AN ERA OF TIGHTENING RESOURCES, WE MUST BE AWARE OF CERTAIN DEMOGRAPHIC REALITIES -- BUT NOT BE DIVIDED BY THEM.

WE NEED, THEREFORE, TO EVALUATE ALL OUR PRIORITIES AND MAKE SURE THAT THE PARTICULAR POPULATION GROUP YOU IDENTIFY WITH IN YOUR OWN PROFESSIONAL LIFE DOES GET ITS FAIR SHARE OF AVAILABLE RESOURCES ... BUT NOT AT THE EXPENSE OF ANY OTHER GROUP.

MY LAST AGENDA ITEMS -- TWO OF THEM -- HAVE TO DO WITH THE FUTURE ROLE OF THE PUBLIC HEALTH PROFESSION ... EVEN OF THIS ASSOCIATION ITSELF.

THESE ITEMS WERE STIMULATED BY THE RECENT REPORT OF THE INSTITUTE OF MEDICINE ENTITLED THE FUTURE OF PUBLIC HEALTH.

LET ME SAY AT THE OUTSET THAT I BELIEVE MANY PARTS OF THE REPORT WERE UNFAIRLY NEGATIVE TOWARD PUBLIC HEALTH PERSONNEL. AND FRANKLY I'M DISAPPOINTED THAT THERE WERE PUBLIC HEALTH PEOPLE WHO WERE ON THE I.O.M. COMMITTEE WHO APPARENTLY SUPPORTED THE FULL REPORT AND THE STATEMENTS IN IT.

I DO NOT. HOWEVER, I WILL USE ITS APPEARANCE AS A POINT OF DEPARTURE TO RAISE MY LAST TWO AGENDA ITEMS.

FIRST, I DO BELIEVE THAT THE PUBLIC HEALTH LANDSCAPE HAS CHANGED SIGNIFICANTLY OVER THE PAST 8 YEARS AND THAT THE CHANGE IS PERMANENT.

IN OTHER WORDS, PRESIDENT REAGAN WAS ABLE TO COMPLETE THE SHIFT TO A "NEW FEDERALISM," AN ARRANGEMENT IN WHICH THE "CENTER OF GRAVITY" OF HEALTH POLICY AND PLANNING SHIFTED AWAY FROM WASHINGTON AND TOWARD THE STATES AND LOCALITIES.

I SAY THAT PRESIDENT REAGAN "COMPLETED" THIS SHIFT BECAUSE, AS YOU KNOW EVEN BETTER THAN I, THE SHIFT BEGAN UNDER PRESIDENT NIXON AND CONTINUED UNDER PRESIDENT CARTER.

THE I.O.M. REPORT CITES THE "DISARRAY" IN PUBLIC HEALTH, BUT I SUSPECT THAT MUCH OF THIS SO-CALLED "DISARRAY" IS MORE APPARENT THAN REAL AND IS NOT SO MUCH "DISARRAY" AS IT IS THE NATURAL -- ALBEIT MESSY -- PROCESS OF READJUSTMENT AND REALIGNMENT ON A NATIONAL SCALE.

I'D SAY THAT THE I.O.M. COMMITTEE WAS HAMPERED IN ITS WORK BY THE LIMITED INFORMATION AVAILABLE CONCERNING NOT ONLY THE EXTENT TO WHICH THE STATE-BY-STATE REALIGNMENTS HAVE OCCURRED, BUT ALSO THE EXTENT TO WHICH THOSE REALIGNED PROGRAMS ARE <u>WORKING</u> AT THE STATE AND LOCAL LEVEL.

I DON'T THINK ANYONE REALLY KNOWS ALL THE FACTS YET, RELATIVE TO THE "NEW FEDERALISM" IN PUBLIC HEALTH. AND NO ONE SEEMS TO BE SPENDING VERY MUCH TIME TO FIND OUT, EITHER.

BUT THERE IS A RESERVOIR OF SUCH INFORMATION AND IT IS RIGHT HERE IN THE A.P.H.A. HERE ALSO ARE THE PEOPLE -- THE BROAD RANGE OF PUBLIC HEALTH PROFESSIONALS -- WHO HAVE THE STRONGEST MOTIVATION TO GET THE TRUE STORY OUT TO THE AMERICAN PEOPLE.

AND I BELIEVE YOU SHOULD TAKE UP THE CHALLENGE LAID DOWN BY THE I.O.M. COMMITTEE.

I DO NOT BELIEVE THAT THE CURRENT PUBLIC HEALTH SYSTEM IS "A SHATTERED VISION." WE'RE ACHIEVING AMAZING THINGS FOR THE AMERICAN PEOPLE IN TERMS OF HYPERTENSION SCREENING, PRENATAL CARE, SAFE DRINKING WATER, EMERGENCY MEDICAL SERVICES, DENTAL HEALTH, HIGHWAY SAFETY, SERVICES TO HANDICAPPED CHILDREN, AND MUCH MORE.

THAT'S HARDLY THE RECORD OF A SYSTEM THAT'S "A SHATTERED VISION" ... A SYSTEM THAT'S IN "DISARRAY" ... OR ONE THAT IS STYMIED BY SO-CALLED "BARRIERS TO EFFECTIVE ACTION."

I JUST DON'T THINK THAT'S SO. AND I DON'T THINK YOU DO, EITHER.

BUT I DO THINK WE OUGHT TO PAUSE AND ASK WHY SUCH A REPORT COULD HAVE BEEN WRITTEN? I BELIEVE THE ANSWER LIES IN THE FACT NOBODY HAS DONE THE TOUGH HOMEWORK TO GET AT THE TRUTH OF THE SITUATION.

AND WHAT PEOPLE ARE BETTER EQUIPPED THAN THE MEMBERS OF THIS ASSOCIATION?

I BELIEVE IT IS IN YOUR OWN BEST INTEREST -- AS WELL AS THE COUNTRY'S -- TO GAIN AN ACCURATE, IN-DEPTH ASSESSMENT OF WHERE WE ARE AND HOW WE'RE DOING IN PUBLIC HEALTH ... NOW THAT THE TRANSITION IS VIRTUALLY COMPLETE OF PUBLIC HEALTH AS AN ERSTWHILE WASHINGTON-CENTERED ACTIVITY TO A NOW-AND-FUTURE STATE-CENTERED ACTIVITY.

AND NOW FOR MY FINAL AGENDA ITEM. AND, AGAIN, IT PERTAINS TO YOU AS PROFESSIONALS AND TO THE ROLE OF THE A.P.H.A. ITSELF.

FIRST, LET ME SAY THAT ONE OF OUR PROBLEMS IN HEALTH CARE IS THAT THAT VERY PHRASE -- "HEALTH CARE" -- HAS BECOME VIRTUALLY SYNONYMOUS WITH THE PHRASE "MEDICAL CARE." IN FACT, WHEN THE PUBLIC RAISES QUESTIONS ABOUT THE "HIGH COST OF HEALTH CARE," THEY REALLY MEAN THE "HIGH COST OF MEDICAL CARE."

AND, TO A CERTAIN EXTENT, THE AUTHORS OF THE I.O.M. REPORT HAVE MEASURED THE "HEALTH CARE DELIVERY SYSTEM" AGAINST A STANDARD THAT IS MORE PROPERLY THAT OF THE NARROWER, MORE SPECIFIC, AND MORE EASILY MEASURABLE "MEDICAL CARE DELIVERY SYSTEM."

WHY IS THERE THIS CONFUSION, WHEN YOU AND I KNOW THERE IS A DIFFERENCE BETWEEN "HEALTH CARE" AND "MEDICAL CARE"?

WELL, YOU AND I MAY KNOW ... BUT THE REST OF THE COUNTRY DOES NOT KNOW. AND YOU CAN'T BLAME THEM FOR NOT KNOWING, BECAUSE THE FAULT IS REALLY OURS.

WE'VE ALLOWED THIS CONFUSION TO TAKE PLACE BECAUSE WE OURSELVES HAVE NOT TRULY FOCUSED ON PUBLIC HEALTH PRACTICE IN A SYSTEMATIC WAY. FOR EXAMPLE ...

* WE'VE NOT TRIED TO IDENTIFY THE BOUNDARIES OF THE HEALTH CARE DELIVERY SYSTEM. QUITE THE CONTRARY, WE'VE ALLOWED OTHERS -- AND OURSELVES -- TO ERASE THE FEW BOUNDARIES THAT MAY HAVE EXISTED.

* SIMILARLY, WE'VE NOT INSISTED ON DISCRETE AND CONSISTENT DEFINITIONS FOR THE PRACTITIONERS WITHIN THAT DELIVERY SYSTEM. ON THE ONE HAND, THAT APPROACH HAS PROVIDED US WITH GREAT GROWTH AND FLEXIBILITY; ON THE OTHER HAND, SUCH AN APPROACH MAKES IT DIFFICULT TO DEFEND OUR FIELD AGAINST THE KIND OF CRITICISM FOUND IN THE I.O.M. REPORT.

* AND RELATED TO THIS IS THE FACT THAT, UNLIKE THE "MEDICAL CARE SYSTEM," WE DO NOT HAVE AN ACCREDITATION PROGRAM FOR GRADUATES OF "PUBLIC HEALTH" EDUCATIONAL INSTITUTIONS WHICH WOULD ASSURE THE AMERICAN PEOPLE THAT THEY HAVE INDEED ATTAINED A CERTAIN MINIMUM LEVEL OF SKILLS AND KNOWLEDGE AND HANDS-ON EXPERIENCE.

* AND FINALLY, WE DO NOT HAVE A PROGRAM OF CREDENTIALING WITH MANY SUPERVISED PRACTICE SITES IN WHICH FUTURE PUBLIC HEALTH PRACTITIONERS MAY BE OBSERVED AND EVALUATED BEFORE THEY ARE PERMITTED, AS LICENSED PROFESSIONALS, TO DELIVER HEALTH CARE TO THE PUBLIC.

IN OUR OWN PUBLIC HEALTH SERVICE, FOR EXAMPLE, WE HAVE PHYSICIANS, NURSES, PHARMACISTS, SANITARY ENGINEERS, AND SO ON -- 11 DISCIPLINES IN ALL -- WHICH REQUIRE SOME TYPE OF STATE LICENSING OR CREDENTIALING. BUT THERE IS NO SUCH REQUIREMENT FOR THE PRACTITIONER OF THE KEY DISCIPLINE OF PUBLIC HEALTH: THAT IS, THE MASTER OF PUBLIC HEALTH.

I THINK IT MIGHT BE TIME TO LOOK SQUARELY AT THAT ISSUE.

YOU MAY RECALL THAT, IN 1910, ABRAHAM FLEXNER PRODUCED A REPORT ON THE STATUS OF MEDICAL PRACTICE. ITS CLEAR AND HARD-HITTING CONCLUSIONS WERE RESPONSIBLE FOR THE RE-SHAPING OF MEDICINE, RAISING IT FROM A HAPHAZARD VOCATION TO AN ORGANIZED AND TRUSTED PROFESSION.

I DON'T SEE THE I.O.M. REPORT AS BEING IN THE SAME CATEGORY AS THE "FLEXNER REPORT." BUT I DO SEE ITS POTENTIAL FOR GETTING US STARTED ALONG THE PATH OF REEXAMINIATION OF THE PUBLIC HEALTH SYSTEM, WITH THIS OBJECTIVE:

> TO RECOGNIZE THAT THERE <u>IS</u> SOMETHING THAT CAN BE CALLED "PUBLIC HEALTH PRACTICE" AND THAT IT CAN BE AS CREDIBLE, AS ORGANIZED, AND AS TRUSTED AN ACTIVITY AS "MEDICAL PRACTICE" IS TODAY.

IF WE CAN FOCUS ON THIS TASK, THEN I BELIEVE WE'LL BE ABLE TO SAY TO THE AMERICAN PEOPLE THAT ALL THE INDIVIDUALS WHO DELIVER PUBLIC HEALTH SERVICES HAVE HAD THE FORMAL TRAINING AND THE SUPERVISED EXPERIENCES -- AND HAVE THEREFORE EARNED THE APPROPRIATE CREDENTIALS -- TO MAKE THEM ELIGIBLE TO PERFORM THEIR IMPORTANT TASKS.

I THINK THIS IS A HIGH-PRIORITY ISSUE FOR THE SCHOOLS OF PUBLIC HEALTH ... FOR THE PEOPLE IN THE PROFESSION ... AND FOR THIS ASSOCIATION ITSELF.

AGAIN, I DON'T RAISE THIS QUESTION AS A WAY OF RESPONDING TO THE I.O.M. REPORT. IT'S NOT AN ADEQUATE RESPONSE BY ITSELF.

HOWEVER, SOME OF THE CRITICISMS IN THE REPORT MAY NOT HAVE BEEN WRITTEN -- OR MAY HAVE SUBSTANTIALLY MUTED -- IF THERE WERE LESS CONFUSION ABOUT SUCH TERMS AS "PUBLIC HEALTH PRACTICE" AND "HEALTH CARE DELIVERY."

AND NOW, I KNOW I'VE TAKEN UP A GREAT DEAL OF YOUR TIME, SO I'LL CLOSE MY REMARKS WITH THIS OBSERVATION ... AND IT'S A PERSONAL ONE.

WHEN I ARRIVED IN WASHINGTON SOME 7 YEARS AGO, THE ATMOSPHERE WAS HIGHLY CHARGED AND BITTER. I WAS TOLD I WAS TOO OLD ... TOO NARROW-MINDED ... TOO INEXPERIENCED TO BE SURGEON GENERAL.

AND FOR A WHILE I WAS SWEPT INTO THIS ACRIMONIOUS DEBATE.

DURING THAT PERIOD I DID NOT HAVE MUCH OF A CHANCE TO GET TO KNOW AND MEET THE PEOPLE WHO CONDUCT THE PUBLIC HEALTH AFFAIRS OF OUR COUNTRY ... FEDERAL, STATE, LOCAL, AND PRIVATE PHILANTHROPIC.

FORTUNATELY THAT BITTER PERIOD CAME TO AN END AND I WAS ABLE TO GET ON WITH MY JOB AND ABLE TO GET TO KNOW PEOPLE AND RESPECT THE COMMUNITY OF PUBLIC HEALTH PROFESSIONALS.

AND IT HAS BEEN A VERY REWARDING EXPERIENCE EVER SINCE. I'VE COME TO KNOW YOUR COUNTERPARTS IN OTHER COUNTRIES AND OTHER CULTURES ... AND YOU ALL BURN WITH THAT SAME BRIGHT FLAME OF DEDICATION TO THE CAUSE OF HELPING EVERY HUMAN BEING LIVE A HEALTHIER, SAFER, AND LONGER LIFE.

FOR A FEW YEARS, IT'S BEEN MY PRIVILEGE TO HAVE BEEN WARMED BY THAT FLAME ... TO HAVE SHARED IN YOUR PROFESSIONAL LIVES ... TO HAVE ADOPTED YOUR GOALS FOR THE HEALTH OF OUR PEOPLE ... AND TO HAVE SEEN THE WORLD THROUGH THE SAME LENS OF HOPE THAT IS YOUR LENS.

I'M TRYING TO PUT DOWN ON PAPER SOME OF THE THINGS I'VE LEARNED ALONG THE WAY. AND I HOPE TO GET DOWN SOME OF THE GOOD THINGS I'VE LEARNED ABOUT THE PUBLIC HEALTH PROFESSION AND ABOUT THE PEOPLE WHO SERVE IN IT.

BUT I'M A DOCTOR, NOT A WRITER, AND I MAY NOT GET IT ALL DOWN JUST RIGHT. SO, JUST TO MAKE SURE YOU UNDERSTAND, LET ME SAY "THANK YOU" TO THE AMERICAN PUBLIC HEALTH COMMUNITY FOR BEING THERE ... YESTERDAY, TODAY, AND TOMORROW.

THANK YOU.

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